HealthAlliance with Physicians
60 Hospital Road Leominster, MA 01453
tel. 978-466-4381 fax. 978-466-4029
www.healthalliancewithphysicians.com

June 17, 2011

By email (costtrends@hcf.state.ma.us **)**

Seena Perumal Carrington, Acting Commissioner
Executive Office of Health and Human Services
Division of Heath Care Finance and Policy
Two Boylston Street
Boston, MA 02116

Dear Acting Commissioner Carrington:

On behalf of HealthAlliance with Physicians, Inc, (HAPI), enclosed please find my written testimony in response to "Exhibit B" and "Exhibit C" of the Division of Health Care Finance and Policy's letter to me dated May 27th, 2011. We appreciate the opportunity to discuss these important issues with you.

Please let me know if we can be of further assistance.

Sincerely,

John. S. Minichiello
John S. Minichiello
Executive Director

Exhibit B: Instructions and Questions for Written Testimony

Instructions:

On or before the close of business June 15, 2011, electronically submit written testimony signed under the pains and penalties of perjury to: costtrends@hcf.state.ma.us.

Answer all questions that apply to your organization's experience, limiting your response to no more than 500 words per each numbered question. Please begin all responses with a brief summary not to exceed 120 words. If necessary, please include supporting testimony in an Appendix.

The testimony must contain a statement that the signatory is legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

If you have any questions regarding this process or regarding the following questions, please contact: Stacey Eccleston, Assistant Commissioner for Health Research and Policy, at Stacey.Eccleston@state.ma.us or (617) 988-3276.

Summary

HealthAlliance with Physicians, Inc. (HAPI) is the Physician Hospital Organization (PHO) that partners **CentMass Association of Physicians Inc.** with **HealthAlliance Hospital**, a member of UMass Memorial Health Care.

HAPI was initially formed by its members to serve as a vehicle for joint participation in managed care risk contracts. The major areas of responsibility of the HAPI organization are to negotiate and administer managed care contracts and to provide hospital and community case management services on behalf of its members to the covered lives within HAPI's managed care risk contracts.

HAPI has participated in global risk contracts with Tufts Health Plan's Commercial and Medicare Preferred products, Harvard Community Health Plan, and Blue Cross Blue Shield of Massachusetts.

Questions:

1. After reviewing the preliminary reports located at *www.mass.gov/dhcfp/costtrends,* please provide commentary on any finding that differs from your organization's experience. Please explain the potential reasons for any differences.

Response:
HAPI has the following commentary upon reviewing the preliminary reports:

1. In the population that HAPI serves, the delivery of more routine inpatient services is not concentrated in higher paid hospitals. HAPI's members provide a range of timely and coordinated healthcare services and believe strongly that the method for delivering the most efficient, effective and equitable care possible is often best found in a local community setting. Within the risk contracts that HAPI participates in, an incentive exists to provide care in a high quality and cost effective local setting. Regarding the care that leaves the local community, as was reported in price variation report distributed by the Division of Health Care Finance and Policy, HAPI has observed an increasing level and trend of prices for hospital and physician services elsewhere.

2. The report's observation that "lower priced hospitals are often associated with slightly higher quality scores and vice versa" needs considerably more investigation and supportive information as HAPI does not see this as an outcome of any particular policy or initiative. More in depth study and analysis would need to take place to make this conclusion, or for that matter, making any connection of price to quality in Massachusetts.

3. The DHCFP's report suggested approach (for addressing the wide variation in private payer prices among hospital inpatient, physician and professional services) to narrow a pricing range spanning the existing 20th percentile to 80th percentile of payments on the surface appears to be a quite arbitrary method. The potential total savings of this ($267 million) is not completely insignificant, but the method is not substantiated enough in the overall context of this approach. Controlling spending directly correlates with payment rate inflation. The heart of the private payer price disparity conundrum lies within the methods and motives of those that negotiated these prices. It was not a total surprise that the private payer pricing disparity uncovered in the report exists, as there did not appear to have been an adequate control within the system to contain or prevent it. The current insurance marketplace in Massachusetts has only a few major health plans comprising the market. These plans have publicly expressed the challenges of having to negotiate pricing with a handful of ever expanding, leveraged, healthcare system networks.

   Managed care in the 1990's brought about provider price reductions in Massachusetts, as the purchasing power of the insurance companies enabled them to negotiate price discounts with the providers. One outcome of this action led to a consolidation of

providers. Unfortunately, going forward, the goal of many providers outside of these major networks is to join one, in order to take advantage of negotiation leverage.

However, the pricing alone does not explain the healthcare spending variations in comparing Massachusetts to other states, or in comparing healthcare spending in Massachusetts from one town or city to another. The utilization variation that exists across the commonwealth is also a large driver. Perhaps greater transparency in pricing, utilization and quality can contribute to bending the cost curve.

4. The report's preliminary finding of no correlation between a hospital's share of Medicaid patients and the prices they received from private payers should not disprove providers' assertions that higher private payer prices are needed to compensate for losses incurred by lower Medicaid payments. Government underpayment is a significant contributor of the desire of providers to negotiate escalating private payer rates. The provider community has publicly mentioned significant Medicaid cost shifting pressure.

2. How much have your costs increased from 2005 to 2010? (Percents by year are fine.)
    a. Please list the top five reasons for these increases, with the most important reason first.

Response:

HAPI's cost increases were

2005- 2006:	6%
2006 – 2007:	11%
2007- 2008:	10%
2008 - 2009:	8%
2009 – 2010:	5%

Reasons for increases:

- Salaries and benefits expense
- Accounting and audit expense
- Liability and workers compensation expense
- Information technology expense
- Purchased database services

3. What specific actions has your organization taken to contain health care costs? Please also describe what, if any, impact these strategies have had on health care costs, service quality, and patient outcomes. What current factors limit the ability of your organization to execute these strategies effectively?

Response:

HAPI has historically participated exclusively in global payment contracts with Tufts Health Plan's Commercial and Medicare Preferred products, Harvard Community Health Plan, and Blue Cross Blue Shield of Massachusetts. In doing so, HAPI has acknowledged that utilization management is a critical component in improving access, quality and efficiency.

In order to maximize performance within these contracts, HAPI has developed many actions and initiatives to contain health care costs within these contracts. All of these initiatives required investment in infrastructure. The following are some examples of these actions:

- Developed initiatives to increase the market share of care provided by HAPI's providers practicing in lower cost, community settings.
- Employed inpatient and outpatient case management staff.
- Developed claims utilization data management systems for:
    a. Provider profiling
    b. Expense trending
    c. Complex case finding
    d. Market share profiling
- Created and staffed medical management and quality assurance committees.
- Developed sub capitation payment arrangements.
- Purchased provider excess reinsurance at a cost lower than health plan offerings.
- Developed disease management programs and patient educational materials.
- Obtained health plan grants in order to experiment with new methods of utilization management and quality improvement.
- Developed various performance incentive programs and risk sharing methodologies among the physicians and hospital.
- Developed programs to promote the use of generic medication.
- Created initiatives to prevent patient falls and reduce readmissions.
- Collaborated with an insurance company initiative that utilized a nurse practitioner in order to round on SNF patients.
- Developed initiatives to increase compliance with ambulatory HEDIS measures.
- Implemented an effort to ensure discharged patients receive a phone call and have an appointment with their PCP within 72 hours of discharge to prevent readmissions.

We believe these strategies have had an impact on cost, service quality and outcomes. Direct correlation has proved quite challenging, and often the "soft" measurement is more obtainable than the "hard" one. The method of measurement is challenging, and often factors hinder the ability to develop a reliable return on investment or direct correlation to a specific initiative.

Some of the limiting factors for executing strategies effectively are:

- Patient compliance and unlimited patient choice among health care providers.
- Provider adoption and support of these and other initiatives.
- Limits in technology and connectivity.
- Lack of financial resources for infrastructure.
- Differentiating health plan roles from provider roles in developing strategies.

4. What types of systemic changes would be most helpful in reducing costs without sacrificing quality and consumer access? What systemic actions do you think are necessary to mitigate health insurance premium growth in Massachusetts? What other systemic or policy changes do you think would encourage or help health care providers to operate more efficiently?

Response:
Below are some suggestions for systemic changes to address these issues:

- Embark on pilot studies of providers that are reimbursed on alternative payment methodologies (e.g. global payment, episodic payments, course of treatment payments) making sure to include representation of the very broad variety of provider organizations and systems.
- Encourage routine care at appropriate and less expensive settings.
- Analyze the deployment of high cost of technology and the "medical arms race".
- Establish financial incentives and grant funds designated for proven processes that have increased coordination of care within provider systems, to include the promotion of systems of care, rather than care provided within silos.
- Engage employers, patients, providers, payers, and government in new ways in order to collaborate in bending the cost curve.
- Financially reward high quality in some manner, and reducing payment for poor quality.
- Design thoughtful provider price, quality and utilization transparency programs.
- Promote the use of community level of care and/or care in less costly settings.
- Develop new insurance products bridging employers, payers and providers in new ways.
- Introduce and employ more cost-effectiveness analysis within healthcare systems.
- Publicly report provider process and outcome measurement capabilities- initially process measures on the greater proportion of costly services whereby outcome measurement is still in its infancy, and outcome measurement on any service whereby the preferred outcome is known and accepted.
- Increase accountability on providers to organize care, improve handoffs and transitions.
- Promote processes of care delivery that underlie particular treatments such that systems organize around key clinical processes of common illnesses. e.g. diabetes, CHF
- Pursue provider incentive models directed at improving upon delivery of clinical care along disease states and course of treatment for common diseases.
- Encourage cost reduction through lean management techniques.
- Promote low cost sites of care and integrated care models.
- Set statewide hospital readmission reduction targets.
- Pursue medical malpractice reform.
- Educate and encourage the use of palliative care.
- Establish medical home pilots.
- Consolidate and simplify administrative burdens on providers and payers across the entire system

5. What do you think accounts for price variation across Massachusetts providers for similar health care services? What factors, if any, should be recognized in differentiated prices?

Response:
Lack of successful methods to control provider pricing has led to this variation. Whether these controls could be market driven or driven by policy and regulation continues to be debated. However, the current methods of relying on competition to control costs/pricing and improve

quality are flawed. Similarly, assuming the insurance companies that negotiate the prices with providers can maintain adequate, homogenous controls is a wrong assumption. Providers seek to earn margins over the long term, and have not historically been successful in trimming their aggregate expenses. In addition, government underpayment is a significant contributor of the desire of providers to negotiate escalating private payer rates. Thus, for these and many other reasons, providers seek higher prices in order to earn a margin, despite often underutilizing their capacity. The underlying cost structures, negotiating acumen and financial wherewithal of providers across Massachusetts may also be a factor in determining provider pricing. An imbalance of power between fragmented healthcare buyers and consolidating sellers may have occurred in Massachusetts as well, ultimately producing this price variation.

There is some merit to the factors within the Medicare and Medicaid pricing determination system e.g. wages, new technology, outliers. Absent any differentiation, would healthcare service be a commodity? Value, or perhaps marginal value, may be a factor to recognize in differentiated prices. However, the value of healthcare services is not explicitly defined in a meaningful way. Overtime, a qualitative differentiation that accompanied any pricing scheme would be ideal.

6. What policy or industry changes would you suggest to encourage treatment of routine care at less expensive, but clinically appropriate settings? (Routine care is defined here as non-specialty care that could be provided at a community hospital or in a community setting).

Response:
Promoting the use of less expensive settings would be a great place to start. Other considerations include:

- educating the public about the benefits
- maintaining sufficient capacity and access to these settings
- developing insurance products that favor the use of less expensive settings
- creating a level playing field in physician and staff recruitment such that less expensive settings can recruit talent as well as their peers at expensive settings.

7. Which quality measures do you most rely on to measure and improve your own quality of care?

Response:
HAPI case management staff has specifically focused on:

- 30 day hospital readmission rates and SNF readmission
- appropriate utilization of emergency department use (utilization for non-emergent care)
- frequency of falls in seniors
- infection rates, status post elective surgery
- HEDIS outpatient measures
- chronic disease management utilization (Asthma, COPD, CHF & Diabetes)

8. We found that there is substantial price variation occurring for several types of health care services (although for some more than others), but that the wide variation in prices for hospital care does not appear to represent any corresponding gain in quality based on the existing quality measures that we were able to use in this analysis. Does your organization believe that price is correlated with quality? What role do you think quality should play in determining prices, and does the health care community currently collect the right types of quality measures?

Response:
Prior to the viewing of this report, information regarding provider pricing and quality of care has not been available in such a manner to make any correlations of this kind. After the viewing of this report, certainly any correlation between price and quality could be true or merely coincidental. Sufficient information and analysis has not been presented in order to draw a correlation with price and quality across all services of any particular provider.

Quality should play a significant role in determining differential prices. The health care community currently collects a large amount of quality information for a very wide audience, but not necessarily for the intent of sharing this information publicly, or for differentiating between providers. Each segment of this audience e.g. physicians, nursing, administrators, employers, government, consumers, needs to determine, with the healthcare community's guidance, the "right types of quality measures" for their particular purpose, across both inpatient and outpatient settings. The quality measures currently available are less than ideal, whether not in the correct format to allow consumers to choose where to seek their care, or not accessible on a timely basis.

9. We found that for many inpatient DRGs, a large portion of patient volume is clustered in the most expensive quartile(s) of providers. Please provide your organization's reaction to these findings.

Response:
The large portion of patient volume clustered in the most expense quartile of providers probably has to do with several reasons:

- tertiary/academic hospitals effectively serve as the community hospital for many patients.
- perception of the quality or service availability at the tertiary or academic setting promotes their use.
- their reputation in the community and expensive marketing efforts drives volume.
- the employees of these facilities, often a large proportion of residents, use these facilities.
- physician networks of tertiary or academic systems often extend miles beyond their primary service area, and frequently refer to their "home system" hospital.

10. What tools should be made available to consumers to make them more prudent purchasers of health care?

Response:
Tools that can help differentiate providers for consumers would be useful. However, consumers often need education and assistance in order to interpret this information. The internet has

provided a vehicle for easy access to this information. Some useful information made available would be:

- cost of health care services
- the efficacy of services
- understanding the risks and all the alternatives
- access and customer service information
- qualitative differentiation
- as much quality information as possible to include volume and complication rates

11. What are the advantages and disadvantages of complete price transparency (e.g., consumers being able to see what prices are paid by carriers to different providers for different services) from your organization's perspective? What about complete quality transparency?

Response:
Pricing transparency has the following advantages and disadvantages:

Advantages

- Provides information for consumers.
- Highlights unsubstantiated inequity among provider pricing.
- Could promote accountability in managing expenses.

Disadvantages

- Potential exists to see some prices rise.
- Could limit new insurance or provider entrants seeking lower prices.
- Piecemeal approach, rather than a bundle of payment for a particular episode.
- Challenged to ensure equitable, timely access.
- Providers and consumers using the data for the wrong purpose and other adverse consequences.

Full price transparency of all services across all payers should be contemplated at length. It would be beneficial to contemplate how quality data could accompany pricing as well.

Quality transparency has the following advantages and disadvantages:

Advantages

- Promotes accountability.
- Stimulates improvement.
- Provides information for consumers.
- Provides a form of benchmark information.

Disadvantages

- Consumers are challenged to understand the information.
- Early attempts have not shown significant impact.

- Providers and consumers using the data for the wrong purpose and other adverse consequences.
- Requires broad consensus over who disseminates the information and funds the effort.
- Ongoing challenge to determine the clinical significance and overall impact.
- Lacks a standardized evaluation framework.
- A measurement challenge exists, as transparency requires accurate, comparable and complete data.
- Requires consensus among multiple stakeholders and a thorough engagement of providers.

12. Before your organization decides to acquire new service lines, capacity, or major equipment, does it consider the current capacity of nearby providers? What do you feel the state's role should be in health care resource planning (beyond or including its current Determination of Need process)?

Response:
HealthAlliance with Physicians (HAPI) is a PHO and thus does not render services and thus this question is not applicable to HAPI.

13. How ready does your organization feel it is to join, affiliate with, or become an Accountable Care Organization (ACO)? Please explain.

Response:
HealthAlliance with Physicians is concluding its operations at the end of the 2011 calendar year.

14. Does your organization have any direct experience with alternative payment methods (bundled payments, global payments, etc.)? What have been the effects in terms of health care cost, service quality, and patient outcomes?

Response:
HAPI has participated in global risk contracts with Tufts Health Plan's Commercial and Medicare Preferred products, Harvard Community Health Plan, and Blue Cross Blue Shield of Massachusetts. These contracts have engaged our providers considerably and have motivated them to manage utilization and improve quality across both the inpatient and outpatient settings. Their efforts have successfully allowed them to manage within the annual health plan global budgets in these arrangements for the majority of the time. In addition, our providers have frequently achieved honor roll status across the major health plans. As stated in question #3, several specific actions have been taken by HAPI to either directly or indirectly contain health care costs and improve the patient experience through a more coordinated provider effort and patient centered approach. Specific quantification of patient outcomes has been a tremendous challenge for our organization. We have been more successful in measurement of process than outcome at this time.

Regarding global payment, it is not a panacea. Global payment can align some provider's incentives, but incentives also need to be in place for employers, heath plans, consumers, referring providers within outside healthcare systems, and municipalities as well. Global

payment is one payment reform consideration that Massachusetts should consider among a list of many.

15. Please identify any additional cost drivers that you believe should be examined in subsequent years and explain your reasoning.

Response:

a) Measuring, understanding, and managing variation among clinicians and hospitals in their efforts to provide care needs to be examined within Massachusetts. The Dartmouth Atlas has produced many findings related to the impact of variation on total medical expense.

b) The use of high technology, rather than lower cost options, should be examined in Massachusetts.

c) Regionalization of health care should be examined from a strategic stand point, rather than from the perspective of provider attrition or leverage.

d) The organizational types of physician groups in Massachusetts should be examined to determine if Massachusetts should promote one particular model over another. e.g. solo practice, multigroup, clinic models, IPAs, PHOs etc.

e) Behavioral health management should be examined from a few different perspectives. One perspective is how psycho/social issues impact the general health of patients. The other standpoint is how well this care is delivered across both the inpatient and outpatient settings in Massachusetts.

f) The true return on investment of EMR should be examined across Massachusetts.

16. Please provide any additional comments or observations you believe will help to inform our hearing and our final recommendations.

Response:

Other payment mechanisms need to be closely explored in Massachusetts as well. For example, ACO shared savings, the Medical Home, bundled payment, gain sharing, payment for coordination or shared decisions, Pay for Performance (hospitals, physicians) and payment adjustments (e.g. readmissions, infections).

I, John Minichiello, depose and state as Executive Director of HealthAlliance with Physicians, I am legally authorized and empowered to represent HealthAlliance with Physicians for the purpose of this testimony, and that the testimony is signed under the pains and penalties of perjury. I attest that the factual statements provided in the above responses are true and accurate to the best of my knowledge.

John S. Minichiello

John S. Minichiello

Exhibit C: Instructions and AGO Questions for Written Testimony

Instructions

1) On or before the close of business June 15, 2011, electronically submit written testimony signed under the pains and penalties of perjury to: costtrends@hcf.state.ma.us.

2) Answer all questions that apply to your organization's experience, limiting your response to no more than 500 words per each numbered question. Please begin all questions with a brief summary not to exceed 120 words. If necessary, please include supporting testimony in an Appendix.

3) The testimony must contain a statement that the person who signs it is legally authorized and empowered to represent the named organization for the purposes of this testimony, and that the testimony is signed under the pains and penalties of perjury. An electronic signature will be sufficient for this submission.

4) If you have any questions regarding this process or regarding the following questions, please contact: Ashley Reid, Office of the Attorney General, at Ashley.Reid@state.ma.us, (617) 963-2488, or (617) 573-5386 (fax).

Summary

HealthAlliance with Physicians, Inc. (HAPI) is the Physician Hospital Organization (PHO) that partners **CentMass Association of Physicians Inc.** with **HealthAlliance Hospital**, a member of UMass Memorial Health Care.

HAPI was initially formed by its members to serve as a vehicle for joint participation in managed care risk contracts. The major areas of responsibility of the HAPI organization are to negotiate and administer managed care contracts and to provide hospital and community case management services on behalf of its members to the covered lives within HAPI's managed care risk contracts.

HAPI has participated in global risk contracts with Tufts Health Plan's Commercial and Medicare Preferred products, Harvard Community Health Plan, and Blue Cross Blue Shield of Massachusetts.

Questions

1. If you are reimbursed through a contract that establishes a negotiated per member per month amount against which all allowed claims costs are settled for the purposes of determining the amount of withhold returned, surplus paid, and/or deficit charged to you (regardless of whether you are "at risk" or are "upside only"), please explain and submit

supporting documents that show how you quantify, analyze, and project your potential exposure to deficits and/or opportunities for surpluses.

Response:
HAPI currently has four contracts where there is a negotiated per member per month amount or a budget determined relative to a premium or a cost plus based methodology. In these contracts, all included claims costs are settled against the budget revenue. These four contracts are with Blue Cross Blue Shield MA HMOBlue, Tufts Health Plan (Commercial HMO and Medicare Advantage), and Harvard Pilgrim Health Care.

For each contract, HAPI receives claims dataset downloads for all services included in HAPI's risk pool and incurred by a HAPI member in one of these contracts. These data downloads include claims data, eligibility data, pharmacy data and a member months data file. HAPI extracts these files from the plan's bulletin boards monthly and at settlement. HAPI also receives a monthly and a year-end settlement fund report for each of its contracts from the health plans.

At the onset of each contracting year, HAPI develops a budget forecast for each of its contracts using the download data, plan generated fund reports and projected budget information from the plans. HAPI tests and researches the budget information to derive the most complete budget forecast. To the extent possible, HAPI discusses and negotiates some form of stability into the budget so that HAPI has a reliable baseline for a starting budget and in attempt to minimize variability at the time of settlement.

HAPI then estimates medical expenses through trending historical medical expenses in conjunction with information from the clinicians and the hospital on factors that may or are most likely to influence upcoming medical expenses. HAPI has observed variability in its medical expense trends due to a declining population base over time, so that HAPI forecasts at multiple expense projections, e.g. arithmetic mean vs. most recent trend factors, vs. an "outlier" trend factor.

HAPI reports monthly on its financial performance in each contract throughout the year. HAPI will also periodically analyze medical expense and other trends, and will regularly update its contract performance projections, i.e. extent of surplus or deficit. HAPI also projects withhold amounts based on historical medical expense information and relates this projection to forecasted results.

2. Please explain and submit supporting documents that show your internal analysis of your ability to manage any risk you currently bear related to your contracts with commercial insurers, including the per member per month costs associated with bearing risk (risk management costs, staffing, reserves, and stop-loss coverage), projections of deficit scenarios, solvency standards, contingency plans in the event that you run a deficit, or any similar analysis. Please include any analysis you have conducted on how much your costs and risk-capital needs would change based on increases or decreases in risk you bear in relation to your business with commercial insurers.

In addition, please explain the type of data that you currently utilize, or would like to utilize, to manage your performance under a risk budget.

Response:
HAPI uses data supplied by the health plans to analyze per member per month costs associated with bearing risk. Specifically, the data downloads received from each health plan plus the plan generated monthly and settlement fund reports comprise the core information for pmpm medical expense analysis. In addition, HAPI obtains plan benchmark data (e.g. pmpm data on the network or a "blinded" best practice situation, for example), when the plans make this data available to HAPI.

HAPI has one senior analyst, 0.8 FTE and a manager, 1.0 FTE who oversee contracting and data management. HAPI has from time to time utilized the services of a vendor to prepare analytic tools to assist in evaluating or projecting performance.

HAPI regularly quantifies and analyzes medical expense trend data to determine those utilization and cost factors that are contributing to contract performance. HAPI evaluates the variation in health services, from plan to plan, to determine what categories (e.g. inpatient by service, DRG or facility, outpatient by service, procedure, professional by type, etc.) of cost and utilization are increasing and decreasing. In addition, HAPI analyzes the market share loss to other community hospitals as well as tertiary facilities, including both the impact on utilization and cost e.g. for inpatient services: admissions/ 1,000, ALOS, days/1,000, cost per day, cost per case, DRG adjusted cost per case, variances from prior year(s), and so forth. HAPI is able to drill down to the diagnostic and or procedural level to determine changes in practice pattern or utilization that impact medical expense. In addition, HAPI can review the data at the individual claim level or service line level to determine changes in patterns that may influence performance results.

HAPI also will target certain components of utilization for additional analysis, such as ED utilization, physician office visit trends, high cost case utilization and costs, ambulatory surgery utilization, etc. HAPI will focus on the current years cost and utilization patterns in addition to longitudinal analyses of cost and utilization trends over multiple years.

In addition, HAPI works with the care management staff and physician leadership to determine which situations have the potential to generate unusually high medical expenses. Physicians meet monthly to address their group's performance.

HAPI also has an internal audit function to evaluate the appropriateness of the medical expenses being attributed to the risk pool, for example that HAPI's risk pool includes medical expenses belonging to HAPI members, the providers have been paid correctly, the correct services are included, and so forth. Also HAPI uses an external vendor to annually audit the two largest settlements, by membership, for accuracy.

HAPI determines it budget annually based on staffing and other projected costs. HAPI is funded through the contracts.

HAPI purchases provider excess reinsurance through a reinsurance broker. HAPI has had the same reinsurer (or a subsidiary) since 2002. HAPI's reinsurance premium varies annually and is generally based on the most recent two fully completed years of medical expense trends (gross loss ratios) and the extent of high cost cases that are expected to continue into the subsequent year of risk. HAPI's reinsurance is for catastrophic cases.

As the HAPI partners are liable for the surplus and deficit, HealthAlliance Hospital and CentMass Association of Physicians assume any deficit loss. In the event of deficit, HAPI has historically raised the physician withholds with the health plan(s) in order to cover the physician's share of loss. The HAPI partners each manage their own reserves and how they would accommodate any further deficit.

3. Please explain and submit supporting documents to show the per member per month cost associated with your efforts to integrate or coordination the medical care that you provide to your patients, including but not limited to costs associated with health information technology, medical management programs, pharmacy programs, practice pattern variation analysis, referral pattern analysis, quality process and outcome measures, and other similar care coordination efforts. In addition, please explain the type of data that you currently utilize, or would like to utilize, to better coordinate and manage the cost and quality of the care that you provide to your patients, including but not limited to claims data, health care provider price data, practice pattern variation analysis, utilization analysis, quality data, or other types of data.

Response:

The HAPI organization provides contracting, claims data analysis, and case management services on behalf of its owners. HAPI's per member per month cost for these services is between the range of $4.54 - $5.21 pmpm for the commercial contracts, and $14.03 pmpm for Medicare advantage.

HMO	Member Months	PMPM
Tufts	37953	$4.54
HPHC	31558	$4.87
HMO Blue	116924	$5.21
Tufts Medicare Preferred	45594	$14.03

Currently the data we utilize most often is from payer medical service and pharmacy claims files for all our contracts. We are provided these files on a monthly basis. In addition we capture some data manually, which is then entered into home grown databases. We also rely on health plan utilization and cost reports, and have at times purchased benchmark data from national consultants. We do not have a robust system of data on the providers we refer to outside of our system. We would like to utilize comparative pricing and quality data on providers outside of our system.

4. Please describe current competitive dynamics in the Massachusetts health care provider marketplace and how those dynamics impact your organization, including but not limited to the impact on your organization of (i) differentials in rates paid by payers to providers, (ii) provider consolidation, and (iii) physician hiring trends.

Response:

Providers in Massachusetts often make efforts to expand their market share in many different ways: by emphasizing their reputation, scope of services and technology; by attracting patients through their marketing efforts; and by growing wide networks of physicians that can refer to them. Massachusetts' providers compete along the lines of what combinations of services they can provide although no organization is at "best practice" across all of their services. However, with a resultant combination of high health care expenses in Massachusetts and variable quality, whatever competition is thought to exist does not drive quality and efficiency improvements in health care.

Competition needs to occur at some level that provides value, or more specifically, a differentiation among provider services is needed for consumers so they can make informed decisions. A dearth of outcome results or value-laden data for patients currently exists.

In order to reduce health service prices through price comparison, one would need to assume health care is a type of commodity, but the wide variation in process and outcomes of health care indicates this is not the case. Providers need to compete at a level that provides direct value to patients, and should this level be accompanied with a significant set of outcome results, price differentiation could be established.

The differential in rates paid by payers to providers reported by the Division of Health Care Finance and Policy has had in impact on HAPI in a few manners. As HAPI manages under global capitation, the payments for services provided outside of HAPI's system are quite unpredictable and unsubstantiated. Should providers consolidate, the assumption is that the consolidated group will have additional negotiating leverage which may lead to an even further differentiation of provider pricing. For those provider systems that are on the high end of the range of provider pricing, additional resources might be available within those groups to attract and retain the most talented physicians. Most newly hired physicians that participate within HAPI's contract seek employment of some kind.

5. Please explain and submit supporting documents that show whether and how you inform patients when you are reimbursed for the services that you render to them through a negotiated per member per month amount against which all allowed claims costs are settled for the purposes of determining the amount of withhold returned, surplus paid, and/or deficit charged to you (regardless of whether you are "at risk" or are "upside only").

Response:
HAPI's current payer contracts have not required this form of notice to be given by any providers that are HAPI participating providers. HAPI is a PHO and thus does not render services and thus this question is not applicable to HAPI.

6. Please explain and submit supporting documents that show how you prevent underutilization of needed services and ensured that less-health patients are treated fairly where your organization is reimbursed through a negotiated per member per month amount against which all allowed claims costs are settled for the purposes of determining the amount of withhold returned, surplus paid, and/or deficit charged to you (regardless of whether you are "at risk" or are "upside only").

Response:
HAPI is delegated for medical management in its Tufts Medicare Preferred contract. The scope of the HAPI delegated medical management effort includes the review of patients and addresses the most efficient utilization of resources, including overutilization, underutilization, and inefficient utilization. This is achieved by means of prospective, concurrent, and retrospective review of services on a regular basis to determine the appropriateness and quality of inpatient and outpatient services. Utilization management incorporates managing the appropriate utilization of services by all patients covered by a plan for which HAPI has assumed delegated responsibilities. This includes patients who are in acute and rehabilitation hospitals, skilled nursing facilities, home care and out of system facilities. The utilization review addresses the technical, professional, and clinical aspects of care including efficient ordering practices, appropriateness of level of care, appropriate and efficient use of resources, and effective coordination and communication.

HAPI has established a utilization management and quality assurance committee to serve the following purposes: for problem identification and resolution of utilization management and quality assurance issues; to provide a forum for the establishment of clinical review criteria; to oversee the prospective and retrospective review of appropriate utilization of services; to review utilization data; and to identify utilization and practice patterns relative to peer, regional and/or national benchmarks and practice guidelines.

I, John Minichiello, depose and state as Executive Director of HealthAlliance with Physicians, I am legally authorized and empowered to represent HealthAlliance with Physicians for the purpose of this testimony, and that the testimony is signed under the pains and penalties of perjury. I attest that the factual statements provided in the above responses are true and accurate to the best of my knowledge.

John S. Minichiello
John S. Minichiello